

## **KNOWLEDGE OF THE GENERAL PHYSICIANS ON SURGICAL ETHICS ESPECIALLY ON INFORMED CONSENT AMONG SURGICALLY EMERGENCY PATIENTS IN CHITTAGONG MEDICAL COLLEGE HOSPITAL, BANGLADESH**

Faruquzzaman<sup>1</sup> Seikh Farid Uddin Akter<sup>2</sup> Saroj Kumar Mazumder<sup>3</sup> Suzon Al Hasan<sup>4</sup> Md Mahtab Uddin Hassan<sup>5</sup>

### **Abstract**

This was a cross-sectional study on knowledge of the general physicians on the surgical ethics especially the informed consent among the surgically emergency patients in the various units of the Internal Medicine Department, Chittagong Medical Hospital, Bangladesh.

98 Graduate and 28 post graduate clinicians were included in this study during the period from 15th December 2007 to 15th June 2008.

Majority of the graduate clinicians (53.1%) found to have only some ideas about informed consent whereas in case of post graduate clinicians only 35.7% were found to have the satisfactory ideas about this, but in general the only 2.4% clinicians were found to have excellent and perfect ideas in this relation. A majority group (15.9%) was found who had no satisfactory answer followed by 14.3% had none of any specific preferable nature of informed consent. About 48.9% of the graduate and 28.6% post graduate clinicians were found to have no idea about Nuremberg Code, IRB or NMRC.

### **Introduction**

Informed consent is a very important chapter in our surgically emergency practice as well as it is a legal and formal process in which the individual is first fully informed and gives consent usually in written to participate in a surgical procedure or in a research study or to receive a method or service<sup>1,2</sup>. Informed consent is included in one of the basic principle of research bioethics respect for the person.

1. Internship trainee of Chittagong Medical College Hospital Chittagong
2. Assistant Professor of Community and Family Medicine Faculty of Medicine, International Islamic University of Malaysia
3. Associate Professor of Community Medicine Chittagong Medical College, Chittagong
4. Associate Professor of Physical Medicine and Rehabilitation Chittagong Medical College, Chittagong.
5. Professor of Medicine Chittagong Medical College, Chittagong.

**Correspondence :** Dr Seikh Farid Uddin Akter

Respect for the persons recognizes the capacity and the rights of all individual to make their own choices and decisions. The voluntary consent of the human subject is absolutely essential- the first document of the Nuremberg Code, signals the centrality of the consent in research involving human subjects<sup>3</sup>.

Institutional Review Board (IRB) and sponsoring agency should ensure the voluntary informed consent by researchers. If IRB is not functioning; the National Medical Research Council (NMRC) should take the responsibility to develop standard language and or a standard format for a consent document<sup>4,5</sup>. The ethical requirements in the research or in case of emergency surgery on human are obtained informed consent from the potential subject, need for the subject to desire a health benefit from the experiment and keeping the risk to the subject as small as possible. These requirements for ethical consideration are relevant and very important when experiments are to be performed on human subjects. Ethics can be defined as the moral philosophy or philosophical thinking about mortality. The requirement to seek consent is derived from one of the ethical principle "respect for person". The German philosopher Immanuel Kant of 18th century has used this term in order to uphold the dignity of a person. Respect for person implies that the dignity of the patient as a person be respected regardless of whether the patient is capable of self governance or autonomous being. Taking fully informed consent is a prerequisite for performing a scientific study<sup>6</sup>.

### **Surgical ethics<sup>7-33</sup>**

Ethics and intervention must go in hand. In any other arena of public and private life, if someone deliberately cuts another person, draws blood, causes pain, leaves scars and disrupts everyday activity then he or she will be charged. If the person dies as a result, the charge could be manslaughter or even murder. Of course, it will be correctly argued that the difference between the criminal and the surgeon is that the latter causes harm only incidentally. The surgeon's intent to cure or manage illness and any bodily invasion that occurs only does so with the permission of the patient.

Patients consent to surgery because they trust their surgeons. Yet what should such consents entail in practice and what should surgeons do when patients need help but are unable or unwilling to agree to it? When patients do consent to treatment, surgeons wield enormous power over them, the power not just to cure but to maim, disable and kill. How should such power be regulated to reinforce the trust of the patients and to ensure that surgeon practice to an acceptable professional standard? Are there circumstances in which it is acceptable to sacrifice the trust of individual patients in the public interest through revealing information that was communicated in what patients believed to be conditions of strict privacy?

These questions about what constitutes good professional practice concern ethics rather than surgical technique. Surgeons may be expert in the management of specific diseases but may have little understanding of how much and what sort of information is required for give valid consent to treatment. Surgeons can understand the delicate techniques associated with specific types of procedures without necessarily knowing when these should be administered to patients who are unable to consent at all. Surgeons can recognize their own mistakes and those of colleagues without knowing how much should be said about them to others. And so it goes on.

#### **Informed consent**

In surgical practice, respect for autonomy translates into the clinical to obtain informed consent commencement of treatment. The ward "informed" is important here. Because of the extremity of their clinical need, patients might agree to surgery on the basis of the information at all. Agreement of this kind, however, does not constitute a form of consent which is morally or legally acceptable. For agreement to count as consent to treatment, patients need to be given appropriate and accurate information about:

- 1) Their condition and the response why it warrants surgery.
- 2) What types of surgery was proposed and how it might correct their condition.
- 3) What the proposed surgery entails in practice.
- 4) The anticipated prognosis of the proposed surgery.
- 5) The expected side effects of the proposed surgery.

- 6) The unexpected side effects of the proposed surgery.
- 7) Any alternative and potentially successful treatments for their condition other than the proposed surgery, along with similar information about these.
- 8) The consequences of no treatment at all.

With such information, patients can link their clinical prospects with the management of other aspects of their life and the lives of other for whom they may be normally and/or professionally responsible. Good professional practice dictates that obtaining informed consent should occur in circumstances which are designed to maximize the chances of patients understanding what is said about their condition and proposed treatment, as well as giving them an opportunity to ask questions and express anxieties. Where possible:

- 1) A quiet venue for discussion should be found.
- 2) Written material in the patient's preferred language should be provided to supplement verbal communication.
- 3) Patients should be given time and help to evaluate their own understanding and to come to their own decision.
- 4) The person obtaining the consent should ideally be the surgeon who will carry out the treatment. It should not be –as is sometimes the case- a junior member of staff who has never conducted such a procedure and thus may not have enough understanding to counsel the patient properly.

#### **Maintain standards**

- 1) Watch one, do one, teach one.
- 2) Surgeons have a responsibility never to criticize their colleagues.

#### **Preoperative preparation :**

Available time for preoperative optimization:

- 1) The 4 minute window:

This is the situation when the patient's only chance of survival is with immediate surgery. Surgery cannot await full resuscitation which has to proceed alongside it, as attempts at further resuscitation are proving futile- for example, in the face of exsanguinations hemorrhage. The commonest scenarios are massive hemorrhage from abdominal or thoracic trauma, or from the rupture of traumatic aneurysm. Once bleeding has been controlled, general resuscitation may then be appropriate before definitive surgery.

**Diagram 1**

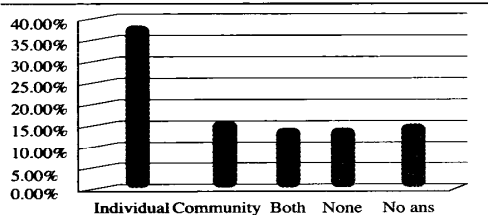


Diagram 2 showing the preferable methods of voluntary informed consent by the clinicians in case of emergency surgery, more details were found from the table III.

**Table III**

Methods	No	%
Verbal	24	24.5
Written	32	32.7
Both	14	14.3
No answer	28	28.8

**Diagram 2**

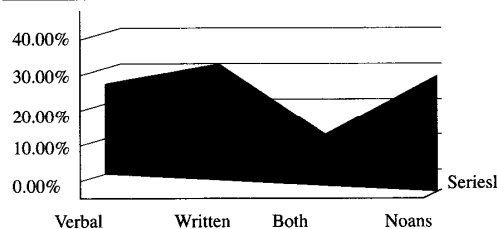


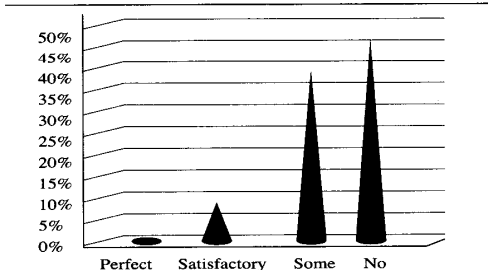
Table IV and V showing the knowledge of the clinicians about Nuremberg Code, IRB or NMRC with the diagram no 3 and 4.

Among the graduate clinicians:

**Table IV**

Knowledge	No	%
Perfect idea	0	0
Satisfactory idea	10	10.0%
Some idea	40	40.8%
No idea	48	48.9%

**Diagram 3**



Among the post graduate clinician:

**Table V**

Knowledge	No	%
Perfect/idea	3	3.6
Satisfactory/idea	6	21.7
Some idea	11	46.4
No idea	8	28.6

**Diagram 4**

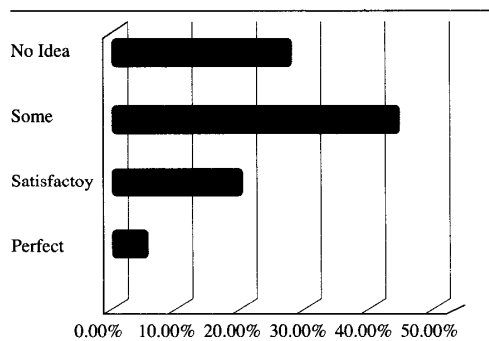


Table VI showing the knowledge of the clinicians about the emergency preoperative consent:

No Graduate clinicians	Perfect idea	Satisfactory idea	Some idea	No idea
98	0 0%	6 6.1%	28 28.6%	64 65.3%
Post graduate clinicians	2 7.1%	6 21.4%	8 28.5%	12 42.9%
28				

**Discussion**

Though this epidemiological study was held in a very small scale but the results those were found were quite alarming as well as horrible. It revealed that the majority of the graduate clinicians (53.1%) were found to have only some and very hazy ideas about the informed consent, whereas in case of post graduate clinicians, the majority group (35.7%) were found to have only the satisfactory ideas but in general the perfect or the excellent ideas were to be found in only 2.4% clinicians and it was quite alarming that about 10.3% were found to have no idea in this connection at all. It may be due to lack of the very basic knowledge in such relation, that is "informed consent is a formal, legal process in which the individual is first fully informed and then gives consent usually in writing to participate in a research study or to receive a method or service<sup>1,2</sup>;

or “respect for persons recognizes the capacity and rights of all individual to make their own choices and decisions. The voluntary consent of the human subject is absolutely essential<sup>4,5</sup>”- were not clear to all of these clinicians. In the question of nature of informed consent, a major group (15.9%) was found who had no satisfactory answer and the 14.3% had none of any specific nature of consent. These were very much important point of this study as well.

In case of methods of consent, about 28.8% clinicians could not give any satisfactory preferable methods and in the question of knowledge about Nuremberg Code, IRB or NMRC, majority group of graduate clinicians (48.9%) were found to be had no idea at all whereas in case of post graduate clinicians, it was as about 28.6%. It was also a matter of great concern that about 65.3% of all graduate clinicians and 42.9% of all post graduate clinicians had no idea about emergency preoperative consent.

#### Recommendation

It is very clear that though the study was held on a very small sample of population in the Internal Medicine Indoor Department, Chittagong Medical College Hospital, Bangladesh, it may be unable to depict the more realistic picture in this connection as a whole, that is in fact the actual situation may be more severe than it is depicted here. Moreover not any satisfactory number as well as level of study in this relation is available in our developing country still now. So the most important pearl is that indeed study in large scale should badly require just now having a more realistic and a more accurate image of this burning as well as alarming problem just now.

It will take more years of debate and research before an original fruitful final conclusion is reached

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